

The right to choose an assisted death: Time for legislation?

Report following a Roundtable in Brisbane, January 2013

“How should Australia regulate voluntary euthanasia
and assisted suicide?”



Bob Douglas, Lindy Willmott and Ben White

Jessica Sparks

is a law and journalism student. She has cystic fibrosis, and at 16 was diagnosed with end-stage lung disease, placed on a breathing machine and told death was imminent. Fortunately she received a double-lung transplant after surviving for a year.



The fact that a peaceful, assisted death is illegal, while much worse alternatives are legally available and much more easily accessible, is disgraceful.

Having been in that suffering, terminal position myself, I understand the debilitating, helpless and inescapable nature of such a situation for patients.

No person should have to endure a quality of life which causes them intolerable suffering and distress.

It is important to note that for each person dying there are friends, relatives and carers who are also affected by such a painful and undignified death.



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4	Foreword from the Chair of Australia21
5	Executive Summary
6	Recommendations
8	Newspoll Survey Results on Public Desire for Reform in 2012
9	PART 1: The Roundtable: a diversity of views on a complex topic. The structure and process of the Roundtable
10	Terminology
10	Areas of broad agreement
11	Themes/perspectives in support of reform
14	Themes/perspectives opposing reform
18	PART 2: Australia21 believes legislative change is needed
19	Why change is needed
23	There is no compelling reason to resist change
27	Selected references
29	Roundtable Participants
31	Acknowledgements

Foreword from the Chair of Australia21

Paul Barratt AO
Chair Australia21



Australia21 is a non-profit body, committed to an analysis of complex issues, which bear on Australia's future. During 2012, the Board was approached with the suggestion that the issues of voluntary euthanasia and assisted suicide would benefit from Australia21's multidisciplinary approach to the exploration of complex policy issues.

We convened a steering group and obtained funds from private donors to explore this issue. A background paper was published on the topic "How should Australia regulate voluntary euthanasia and assisted suicide?" by two senior legal academics from the Queensland University of Technology, Professors Ben White and Lindy Willmott.⁽¹⁾ This paper formed the basis for a roundtable involving a diverse group of doctors, lawyers, former politicians, ethicists, big picture thinkers and activists, including people supporting and opposed to law reform on this topic. There was a constructive dialogue at an all day meeting in Brisbane on 31 January 2013.

This report has two parts. The first part describes the roundtable and some of the key concerns among the participants. It presents the diversity of views on this topic and the background to the arguments that have been used both for and against assisted dying.

No attempt was made to reach consensus between those supporting and opposing reform on this issue but rather the goal was to facilitate a respectful understanding between the two groups.

The second part of the report describes what the authors, writing for Australia21, have concluded from this rich exchange of ideas and concerns, from the transcript of the discussion which included summative statements by all of the participants at the end of the day, and from published literature.

Australia21 hopes that by distributing this report, Australian legislators will be encouraged to engage in this debate with a clearer understanding of the concerns on both sides of the argument.

Australia21's purpose in this report is not to propose a definitive legislative solution to assisted dying – there is already a wealth of documented and evaluated experience on this matter – but to broaden understanding of the difficulties which current Australian law causes for patients and carers alike, and to explain why the authors have concluded that legislative action is now needed.

The legal framework that operates at the end of life in Australia needs to be reformed.

- Voluntary euthanasia and assisted suicide are currently unlawful.
- Both activities nevertheless occur not infrequently in Australia, in part because palliative care cannot relieve physical and psychological pain and suffering in all cases.
- In this respect, the law is deficient. The law is also unfair because it doesn't treat people equally. Some people can be helped to die on their own terms as a result of their knowledge and/or connections while some are able to hasten their death by the refusal of life-sustaining treatment. But others do not have access to the means for their life to end.
- A very substantial majority of Australians have repeatedly expressed in public opinion polls their desire for law reform on these matters. Many are concerned at what they see is happening to their loved ones as they reach the end of their lives, and want the confidence that when their time comes they will be able to exercise choice in relation to assisted dying.
- The most consistent reason advanced not to change the law is the need to protect the vulnerable. There is a concern that if the law allows voluntary euthanasia and assisted suicide for some people, it will be expanded and abused, including pressures being placed on highly dependent people and those with disabilities to agree to euthanasia.
- But there is now a large body of experience in a number of international jurisdictions following the legalisation of voluntary euthanasia and/or assisted suicide. This shows that appropriate safeguards can be implemented to protect vulnerable people and prevent the abuse that opponents of assisted dying have feared. It reveals that assisted dying meets a real need among a small minority of people at the end of their lives. It also provides reassurance to people with terminal and incurable disease that they will not be left to suffer the indignities and discomfort of a nasty death.
- Australia is an increasingly secular society. Strong opposition to assisted death by religious groups that is based on their belief in divine sanctity of all human life is not a justification for denying choice for those who do not share that belief.
- It is now time for Australian legislators to respond to this concern and this experience by legislating to enhance the quality of death for those Australians who seek assisted dying.



Bob Douglas, Ben White and Lindy Willmott

We note:

- a) For the reasons outlined in Part 2 of this report, voluntary euthanasia and assisted suicide should no longer attract criminal sanctions;
- b) Every Member of Parliament (except in the Territories) has the power to introduce a private member's bill on voluntary euthanasia or assisted suicide;
- c) Voluntary euthanasia and assisted suicide bills have generally been decided in Australia by a conscience vote;
- d) Federal Parliament withdrew powers to legislate on voluntary euthanasia and assisted suicide from Australian Territories in 1997; and
- e) Since 1997, a large body of international evidence has accrued from a number of jurisdictions that have successfully legislated to support voluntary euthanasia and/or assisted suicide.

Accordingly, Australia21 recommends:

- a) State governments should develop legislation now to permit and regulate voluntary euthanasia and assisted suicide in defined and limited circumstances;
- b) The Federal Parliament should restore powers that were withdrawn from the Territories so these parliaments may do the same; and
- c) Until the above happens, each Member of Parliament should consider exercising his or her right to introduce a private member's bill on voluntary euthanasia and assisted suicide.

Mr Neil Francis

is Foundation Chair and CEO (now retired) of national voluntary euthanasia law reform group YourLastRight.com, past President and CEO of Dying With Dignity Victoria, and past President of the World Federation of Right To Die Societies.



Late last year, YourLastRight.com commissioned national public opinion research, conducted by Newspoll. The survey of more than 2,500 Australians confirmed ongoing very high public support for legal access to physician-assisted dying in the face of intolerable end-of-life suffering that cannot be relieved.⁽²⁾ Respondents were strongly in favour of this development across age groups, religious affiliation and political affiliation. (see over)

But the study went further. It uncovered that more than a quarter (29%) of Australians said they would change their vote if their otherwise most likely candidate or party stance on assisted dying law reform is opposed to their own stance.

A politician whose stance is opposed to assisted dying law reform will lose considerably more votes at a general election (23%) than a politician who supports reform (6%). A majority of lost votes for "opposed" election candidates applies across all major political parties.

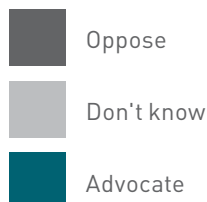
The study also found that voluntary euthanasia law reform was more personally important to voters than other major national issues like the carbon tax, the national high-speed broadband network and gay marriage, and that the views of voluntary euthanasia law reform supporters are on average more deeply held than are views of opponents.

The findings unravel the "truism", long-held by most politicians: the belief that they will be clobbered at the polls if they undertake law reform. The exact opposite may be true.

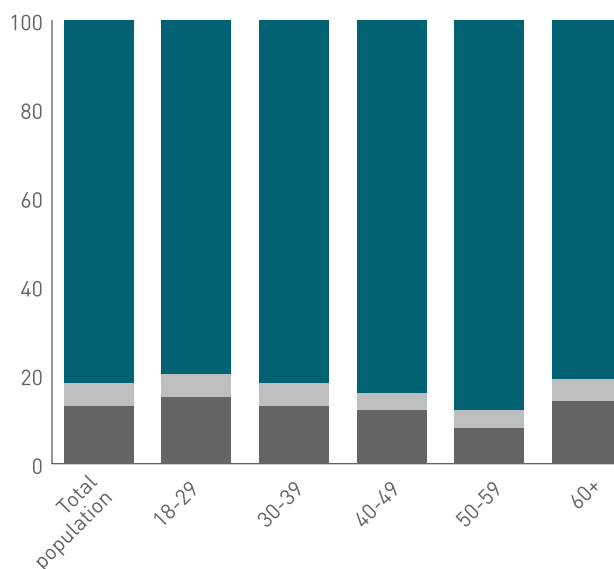


Newspoll Survey Results on Public Desire for Reform in 2012

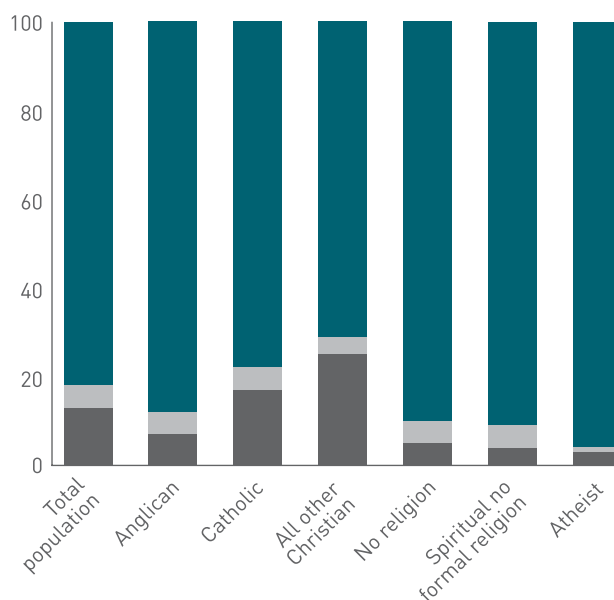
The question asked was: "Thinking now about voluntary euthanasia, if a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering asks for a lethal dose, should a doctor be allowed to provide a lethal dose?"



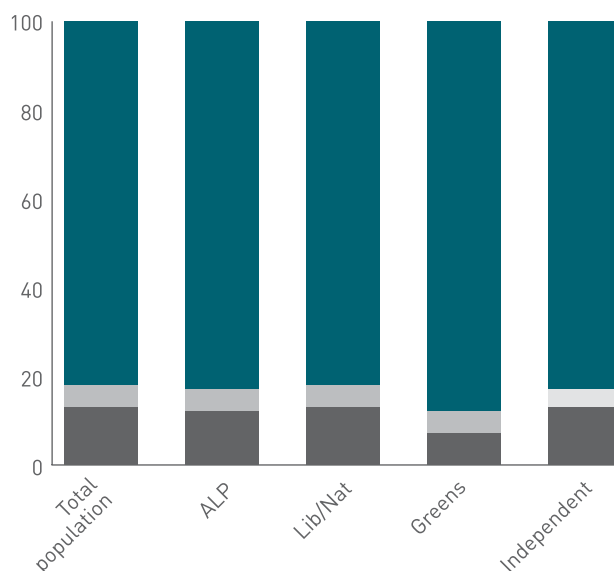
Age group
(doctor can provide a lethal dose)



Religion
(doctor can provide a lethal dose)



Party voting intention
(doctor can provide a lethal dose)



In 2012, Australia21 commissioned a background paper entitled “How should Australia regulate voluntary euthanasia and assisted suicide?”.⁽¹⁾ This paper provided a non-partisan analysis of assisted dying and included a review of:

- The current legal landscape in Australia in relation to medical decisions at the end of life including withholding and withdrawing life-sustaining treatment, the provision of palliative medication that may hasten death, as well as euthanasia and assisted suicide;
- Legislative reform attempts in Australia;
- Evidence on what currently happens in Australia;
- Current law and practice in overseas jurisdictions where voluntary euthanasia and/or assisted suicide are lawful;
- Arguments for and against reform; and
- Possible frameworks for regulating voluntary euthanasia and/or assisted suicide.

Invitations to the roundtable were extended to a number of former and current politicians, ethicists, lawyers, palliative care physicians, representatives of the AMA, nurses, young students and strong advocates as well as strong opponents of voluntary euthanasia and assisted suicide. All participants were invited to respond to the background paper with a series of personal dotpoints that were circulated to all participants prior to the roundtable discussion.

The agenda for the day included open discussions on the following questions:

- What happens at present when seriously ill and dying patients request voluntary euthanasia or assisted suicide?
- What is the evidence that Australians wish for a change in regulation on this matter?
- What are the main arguments in favour of and against legalising voluntary euthanasia and assisted suicide?
- What can we learn from international experience that is pertinent to the current Australian situation?
- What are the political realities surrounding legalisation and/or other regulatory changes on this topic?
- If voluntary euthanasia and assisted suicide were to be legalised in Australia, what regulations and constraints would be required to protect the vulnerable?

At the conclusion of the roundtable, summative statements were made by each participant and these were included in a transcript of the discussion that was circulated to all participants and provided the basis for Part 1 of this report.

Terminology

Terminology is important in this area to ensure a common understanding of the issues being discussed. This report adopts the terminology which was set out in the background paper.⁽¹⁾

The discussion in the roundtable and the recommendations in this report refer to **voluntary euthanasia and physician-assisted suicide**.

euthanasia: for the purpose of relieving suffering, a person performs an action with the intention of ending the life of another person

voluntary euthanasia: euthanasia is performed at the request of the person whose life is ended, and that person is competent

non-voluntary euthanasia: euthanasia is performed and the person is not competent

involuntary euthanasia: euthanasia is performed and the person is competent but has not expressed the wish to die or has expressed a wish that he or she not die

withholding or withdrawing life-sustaining treatment: treatment that is necessary to keep a person alive is not provided or is stopped

assisted suicide: a competent person dies after being provided by another with the means or knowledge to kill himself or herself

physician-assisted suicide: assisted suicide where a doctor acts as the assistant by providing the lethal treatment that the person self-administers.

Areas of broad agreement

Discussions throughout the day revealed broad agreement among participants on a number of key issues:

- The law should be coherent;
- Every person who is dying should have access to high quality palliative care and all health professionals should be aware of the role that palliative care can play;
- Advance care planning has an important role to play in end of life decisions and this should be widely available and understood;
- Every competent person has a right to refuse treatment that they do not want;
- Palliative care cannot deal with all physical, existential or psychological pain and suffering that is experienced by people who are dying;
- Doctors who practise in an ethical and compassionate way should not be exposed to legal risk (though there was not consensus on what constitutes ethical and compassionate practice with respect to voluntary euthanasia and assisted suicide).

On the desirability of changing the current law on voluntary euthanasia and assisted suicide, several different themes emerged. Some of those themes support change and others, that the legal framework should not change. Some of these themes are illustrated by specific comments from participants.

Themes/perspectives in support of reform:

1. Competent adults should be able to make decisions about their own life and death. Increasingly, older or terminally ill people want the security of knowing that they can obtain assistance to end their life if they judge that it has become too burdensome and insufferable or meaningless.
2. Some people are dying in physical, psychological and/or existential pain in a way that should not be tolerated in a humane and compassionate society.
3. The law is unsatisfactory and, in important respects, incoherent.
 - There is uncertainty about what it means to “assist” someone to die, whether a person will be prosecuted if they do so and, if they are prosecuted and found guilty, whether they will be imprisoned.
 - Legal liability for doctors can depend on their intention when treating their patient – did they intend to relieve symptoms or end the patient’s life? Although voluntary euthanasia is illegal in all states and territories in Australia, doctors not infrequently prescribe heavy sedation to patients with intractable pain to relieve their symptoms, even if doing so risks hastening the patient’s death. If their intention is to relieve symptoms, doctors are legally protected by the “doctrine of double effect” even if they foresee the possibility that the sedation will shorten a patient’s life.
 - While there is recognition under the law that a patient can end their life by requesting suspension of unwanted life-sustaining treatment (such as a respirator), a request for active steps to end their life cannot be legally respected.
4. Lives are currently being ended despite existing prohibitions on voluntary euthanasia and assisted suicide.
 - Some individuals take their own lives by suicide (eg. by violent means or, more often recently, by importing illegal drugs from overseas).
 - Some individuals (including family members and doctors who act outside the protection of the doctrine of double effect) take active steps to end a person’s life.
5. Providing requested assistance to die should be part of how those doctors, who are willing to do so, can care compassionately for suffering patients.

Dr Rodney Syme

is a medical practitioner with a 38 year history of active participation in physician-assisted dying.



Dying may be associated with intolerable suffering and there may be a crescendo of suffering as death approaches. A doctor's duty is to relieve suffering. Some suffering will only be relieved by death.

A doctor's duty is to respect his patient's autonomy. Some patients rationally and persistently request assistance to die. Palliative care cannot relieve pain and suffering of all dying patients.

There is a serious lack of appreciation of the importance of psychological and existential suffering at the end of life, and an undue emphasis on physical pain in the debate.

The current law is opaque, ambiguous, hypocritical and unenforceable.



Paul Collins

is an historian, broadcaster and writer. He has taught history and theology in Australia, the US and Pacific countries and worked as a parish priest in Sydney and Hobart.



The issue of voluntary euthanasia and assisted suicide should be withdrawn from the context of the criminal law entirely, with interventions from lawyers, courts, judges excluded virtually completely. The law is a blunt instrument at the best of times but particularly when dealing with sensitive issues such as life and death.

The whole issue is morally complex and sensitive and it is impossible to regulate all of the personal and subjective variables at play in voluntary euthanasia and assisted suicide.

The presumption must be that the patient particularly, as well as their doctor and perhaps with advice from a well-established religious moral tradition, are in the best position to make these kinds of deeply personal decisions.

I support the right to refuse or withdraw life-sustaining treatment.



1. There is a risk that if voluntary euthanasia and/or assisted suicide are legally permitted, the current culture of our society in terms of care and concern for the disadvantaged and people with disabilities will change.
 - There is a risk that there would be a change in societal thinking that would place vulnerable individuals and people with disabilities at risk. Those who need support and care may feel under a duty to “do the right thing” by family and society and accept euthanasia.
 - The increasing focus on individual autonomy and rights, exemplified by legalising voluntary euthanasia and assisted suicide, is undesirable. As a community, we need to focus more on society than the individual. While reform would permit a small number of individuals to exercise a right they consider to be important, this will not result in the overall good for society, which should be responsible for caring for those who are sick and dying.
2. Legalising voluntary euthanasia and assisted suicide will result in a significant and undesirable change in the doctor/patient relationship.
 - Doctors should not be the “takers” of life but rather the “defenders” of life.
 - Doctors have a duty to the “weakest” of their patients, and this duty would be corrupted by introducing a culture of mercy killing.
 - Assisting a patient to die may be regarded by inexperienced and less skilled doctors as an easier option than to work through issues that may underpin a patient’s request to die.
 - Doctors, nurses and other health professionals may feel pressured to be involved in ending life, or referring patients to others who will, contrary to their conscience.
3. The “non-compliance with legislative safeguards” argument: Even if voluntary euthanasia and/or assisted suicide legislation contained adequate safeguards such as limiting the regime to competent adults who are terminally ill and who voluntarily request assistance to die, in practice such safeguards would not be adhered to. The practice would extend, for example, to vulnerable individuals who may feel under emotional pressure to end their lives.
4. The “inevitable expansion of criteria” argument: Even if voluntary euthanasia and/or assisted suicide legislation were limited to competent adults, in due course such legislation would be amended to extend to incompetent adults, or even competent but very sick adults who do not wish their lives to end.
5. A fifth issue – which was not discussed at the roundtable – but is an important aspect of the debate for some is a religious belief in the divinely authorised sanctity of human life. There is a prohibition by some religious groups of all acts that end human life^(1, 3, 4) and these groups have been active in opposing legalisation of assisted dying.

Dr David Van Gend

is a General Practitioner and Senior Lecturer in Palliative Medicine at the University of Queensland Rural Clinical School.



If you are bringing in the machinery of mercy killing, you are corrupting two basic elements: firstly the social contract between the state and its most vulnerable citizens, who will not be claiming the right to die but will be accepting the duty to die. Secondly a change would corrupt the relationship between doctors and their patients.

If you allow doctors to prescribe medicines with the intention of causing death, you have radically changed the nature of the doctor's role and his/her relationship with the patient.

A culture of mercy killing would also transform the social contract between the state and its most vulnerable citizens – or what former Governor-General Bill Hayden called society's "unproductive burdens".

I draw your attention to a key conclusion from the 1994 House of Lords inquiry into medical ethics:^[5] "It would be virtually impossible to ensure that all acts of euthanasia were truly voluntary... We were also concerned that vulnerable people – the elderly, lonely, sick or distressed – would feel pressure, whether real or imagined, to request early death... The committee believed that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death but should assure them of our care and support in life."

For such people, the so-called "right to die" would be felt more as a "duty to die"; to do the right thing by family and society.



Professor Colleen Cartwright

is Professor of Aged Services at Southern Cross University. In 2011, she undertook a major review for Alzheimer's Australia on end-of-life decisions.



End-of-life issues are, by their nature, complex, personal and sensitive, but they are made all the harder if the wishes of the person concerned are not properly understood or set out.

The general reluctance in our society to discuss end-of-life issues translates into a failure by many to prepare properly for the end of life.

There is a need for more discussion, debate and community-wide research to ensure that the complex issues relating to dementia are fully considered.^[16]

It is clear that, even if voluntary euthanasia were to be legalised, it would be wrong to end the life of an individual who does not have the capacity to make the decision and who has not expressed previous wishes.



Dr Alex Markwell

is an Emergency Physician at the Royal Brisbane and Women's Hospital and Greenslopes Private Hospital. She is currently President of AMA Queensland and is a Senior Lecturer at the University of Queensland.



While the AMA recognises that there are divergent views regarding euthanasia and physician-assisted suicide, the organisation currently believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life.

This does not include the discontinuation of futile treatment or the administration of treatment or other action intended to relieve symptoms which may have a secondary consequence of hastening death.

The AMA strongly advocates for the right of a competent patient to make fully informed health care decisions, including the right to refuse treatment. The AMA recognises that this may include life-sustaining treatment as well as palliative care.

The AMA strongly promotes advance care planning as a process of supporting patient self-determination, including the development of advance directives and the identification of surrogate decision-makers such as Enduring Powers of Attorney (or similar), as a means to ensure that the patient's values and goals of care are known. Advance care plans are prepared by the competent patient to assist in decision-making if he or she loses the capacity to make treatment decisions in the future.

While the need for access to voluntary euthanasia and assisted suicide may be a simple issue for patients, it is more complex and ambiguous for doctors and carers. The ambiguity has led to significant variation in the kind of end-of-life care that takes place.

If there is to be any progress on this issue there has to be legal protection for doctors. It may be law reform, legalisation, or it may be case law.



Most (but not all) of the roundtable participants considered that the current legal situation is unsatisfactory for many patients and/or their professional carers. Australia21 and the authors of this report agree that legislative change is now needed.

Patients in the terminal phase of their lives not infrequently ask their doctor for help to die. Sometimes, this is simply a cry for help and when symptoms are alleviated (eg. with pain relieving medication), the patient changes their mind. For some, pathological depression can be alleviated with modern psychoactive drugs and counselling. But while palliative care can assist with physical, psychological and existential problems, it cannot adequately manage all suffering in all patients. Some patients genuinely, persistently and rationally request help to end their lives.

If the patient's life is being prolonged by medical means such as respirators, the law allows those life support measures to be turned off at the request of a competent patient. Furthermore, if there is unrelieved pain, doctors can (and do) respond to a patient's (or family's) request for the provision of drugs in sufficiently high doses to relieve symptoms. In this situation, the doctor may foresee that symptomatic relief could shorten life, but provided the doctor's intention is to relieve symptoms, the provision of such medication is lawful. But if the doctor's intent is to shorten life rather than to relieve symptoms, the action may constitute murder.^[1] This is an untenable situation for a compassionate doctor who agrees that the situation is hopeless and that the patient's request is genuine and reasonable.

National polling suggests that this is an issue on which Australians want reform.^[2, 6] There is now extensive international experience to encourage and guide such reform.^[1, 7, 8, 9, 10, 11]

There are a number of compelling reasons why Australia21 supports the view that the law needs to change.

1. The Australian community wants change

Repeated polling has been carried out for 25 years by professional pollsters, and the public has consistently reported overwhelming support in favour of reform.^[2, 6] The question usually explores whether a person supports allowing a doctor to assist a person to end their lives if experiencing unrelievable and incurable suffering. In addition to the Newspan survey reported on page 8, an opinion poll conducted by The Australia Institute in 2012 asked the following question:

If a person is experiencing unrelievable and incurable suffering (physical and/or mental) should a doctor be allowed to help them end their life?

Of the 1400 people surveyed, 71% agreed with the proposition, 12% of people disagreed and 17% were unsure.^[6]

2. The law has failed

For the reasons described below, the current legal framework of prohibition has failed.

a) Deaths are currently occurring contrary to the law

Research among Australian doctors caring for seriously ill patients has documented current practices in some detail.^[12, 13] According to that research, voluntary, involuntary and non-voluntary euthanasia all occur in Australia in defiance of the law. Some doctors have admitted publicly that they have acted with intent to end the patient's life but, despite this admission, they have not been prosecuted.

Kuhse et al concluded that in 1995-1996, 1.8% of all deaths in Australia occurred as a result of voluntary euthanasia and 0.1% were due to physician-assisted suicide. Despite these actions being unlawful in Australia, the incidence was broadly comparable with that in permissive jurisdictions.^[13] Other research demonstrates that some doctors who treat terminally ill patients intend to shorten life (rather than only relieve pain) when they administer pain relieving medication, and so will be acting unlawfully.^[12]

b) The current law is incoherent or illogical

There are a number of aspects of the law in relation to the end of life care which are incoherent or illogical:

- Withdrawal or withholding of life-sustaining treatment that results in a person's death may be lawful, but the provision of a lethal dose intended to cause death is not;
- Terminal sedation may be lawful, but can also be unlawful depending on the doctor's intention when giving the medication;
- Suicide is legal, but assisting someone to commit suicide is illegal;
- There is a lack of clarity about what is meant by "assisting" someone to die;
- Even in a clear case where a person has "assisted" another to die, some individuals are prosecuted and jailed for providing that assistance, and others are not.

c) The law fails the principle of "equality before the law"

The Rule of Law requires that law must apply equally to all, but this is not the case in this field. Whereas some may be able to end their own life, another person's disability may prevent them from doing so. Further, a person who is ill and relying on life-sustaining treatment to survive (such as a respirator) may lawfully ask for that equipment to be turned off. Another person who is equally ill, but suffering from a different condition which does not require such treatment, cannot be assisted to die.

At present, there are some who can access voluntary euthanasia and assisted suicide despite it being unlawful. Those people are generally able to do so because they possess some privilege. It may be privilege in terms of education or it may be in relation to contacts and connections one has within the medical or veterinary professions. The operation of the law cannot be justified if a privileged few are able to receive assistance to die, but others cannot.

d) *Non-compliance with the law
brings the law into disrepute*

Repeated breaches of the law, particularly where they are made public and not prosecuted, undermine the Rule of Law. This becomes even more problematic for the Rule of Law, if that non-action in the face of illegality is a position that is generally endorsed by a large majority of the community.

**3. Some terminally ill patients
feel forced to choose an
unsatisfactory death**

For some people in the terminal stages of their life, pain or other suffering are relentless and these individuals may take steps to end their own lives. This ending can be violent and painful for the person and traumatic for their family and friends. Many people are attending workshops to seek information on how they can take their own lives when the time is right, in a peaceful way. But for others, the only current alternative is violent.

**4. Palliative care cannot address
all suffering**

The palliative care movement has developed to assist patients with terminal illness when approaching the end of their life. It provides medical support for the relief of symptoms and also nursing, social and spiritual support for the relief of existential suffering. But palliative care, despite its accomplishments, is unable to meet the needs of all patients as they approach the end of their lives. While palliative care can assist with physical, psychological and existential pain, it cannot manage all suffering in all cases.

**Emeritus Professor
Ian Maddocks AM**

is Senior Australian of the Year 2013. He was the first President of the Australian Association for Hospice and Palliative Care (now known as Palliative Care Australia) and first President of the Australian and New Zealand Society for Palliative Medicine. Now aged 81, he continues daily care for the terminally ill.



Palliative care usually has adopted a confrontational position against voluntary euthanasia, recognising its work as supporting living before death rather than assisting death. Other factors are its historical association with Christian (Catholic) concern to preserve life; and a sense that support for euthanasia is a criticism of palliative care expertise.

The process of dying, as palliative physicians come to understand it, is an evolving one, subject to change. Evaluation of the needs of a terminally ill patient requires time and a comprehensive approach, taking in the history and the context of the patient and attending family.

Sometimes a wish to die does stem from “intolerable suffering”, but just what makes a situation “intolerable” may be very individual. Awful pain can usually be addressed; anger, despair, isolation, a concern about finance may all impinge on the scene and are more difficult. Family members usually want to support whatever decision a patient has made, but may also be in contention. One needs time to build understanding about the realities of the whole situation.

I am clearly in favour of decriminalisation of assisted death but I worry about euthanasia being regarded as a “quick fix”.

It calls for the same full appreciation as palliative care physicians seek to bring to their work. Most of us want the right to have a say, but it is appropriate to ask that all death decisions be considered in the light of a full understanding of complex realities, and of close others whom it will affect.



Dr Charles Douglas

is a surgeon specialising in melanoma and breast cancer and a Senior Lecturer in Clinical Ethics and Health Law at the University of Newcastle. His PhD Thesis was "End of Life Decision-Making and Moral Psychology: Intending, Foreseeing, Killing and Letting Die."



Undoubtedly, euthanasia occurs now in various guises in Australia and is likely to continue to occur outside any regulatory guidelines if euthanasia or assisted suicide are decriminalised or legalised.

There is convincing evidence that the majority of Australians are in favour of legalised assisted death.

There is no convincing evidence that the legalisation of euthanasia and/or assisted suicide in the Netherlands and Oregon has caused any significant societal harm.

There is overwhelming evidence that the vast majority of requests for euthanasia are simply "cries for help". This is not to deny the validity of a very small number of requests, but this is a fairly well-established fact accepted by those on both sides of the euthanasia debate.

I am agnostic about the benefits of legislative change. I don't accept that we will have a much better society if it happens, nor do I think it is going to be catastrophic as some opponents of change suggest.

But if we do have legislative change, I think it will have a substantial effect on the national psyche and that the effect could be both positive and negative.



We have demonstrated why we think the law must change. Legislation to legalise assisted dying should be enacted unless there are compelling reasons not to do so. The two major arguments against reform are: 1) concerns that the vulnerable in our community will be placed at greater risk, and 2) the theological view that the divinely conferred sanctity of human life should prevent the intentional taking of life. Neither of these arguments is, in our view, sufficient to resist reform.

1. Safeguards to protect the vulnerable are working well internationally

Since the House of Lords Select Committee on Medical Ethics expressed its view in 1994^[5] that it would be virtually impossible to devise safeguards to prevent abuse of legalised euthanasia, the issue of safeguards has dominated the Australian debate. The concern is that people who are dependent on others may feel a responsibility to seek death, or worse, may be coerced into using it to relieve society or relatives of the burden of caring for them.

Different legislative approaches to safeguards exist in the Netherlands, Belgium and Oregon and these regimes have been in place for long enough to assess their impact. Extensive evaluative data about their operation have been analysed and these, along with considerations such as the need to protect the vulnerable in society, have been considered in detail in many international publications and inquiries^[7, 8, 9, 10] and, more recently, in a discussion paper in Tasmania.^[11] The experience shows that guidelines to protect the vulnerable and ensure that assisted dying is reserved for the group in whose interest it is legislated, are generally operating effectively.

Such data have sometimes been interpreted differently by those who support and oppose legalisation^[14], but discussion at the roundtable supported (though not unanimously) the view that legislation in jurisdictions that have legalised voluntary euthanasia and/or assisted suicide is generally operating without evidence of the kinds of abuses that opponents and the 1994 report of the House of Lords had feared.

Australia21 agrees. It takes the view that the available evidence demonstrates safeguards can be designed to ensure that only “eligible” patients (eg. competent adults who voluntarily request assistance to die and are terminally ill) can receive legal assistance to die, and to ensure that certain conditions (including, for example, the provision of information, obtaining a second opinion and a cooling off period) are satisfied before that assistance is provided.

2. Religious belief in divinely authorised sanctity of human life should not bind others

Strong opposition to assisted death has been mounted by some religious groups on the basis that human life is sacred and divinely given and that therefore killing is divinely prohibited.^[3, 4] This issue was not discussed at the roundtable, but was considered in the background paper.

Australia is increasingly a secular society and it is difficult to defend law and policy that reflects divine understandings of the value of human life. There is now wide acceptance that human life is not an absolute good and that notions of compassion and autonomy can carry greater weight in some circumstances. Further, some religious groups are moving away from more traditional positions and agitating for a more humane approach to assisted dying. The polling data presented on page 8 of this report confirms that strong support for reform spans religious denominations.

Australia21 firmly asserts the right of people to hold and practise religious beliefs. An important concern raised at the roundtable was to ensure doctors, nurses and other health professionals are not required to participate in voluntary euthanasia or assisted suicide contrary to their conscience. However, respect for those beliefs should not bind others who have different beliefs and values, and religious teachings should certainly not be regarded, in our secular society, as a basis for developing law and policy.

Dr Roger Hunt

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I have cared for terminally ill patients who have strongly expressed their wish for help to die. Around 7% of patients with advanced cancer make persistent requests for help to die. While I support patient-centred care and patient autonomy, family and broader concerns can temper these.

There are situations in which a strong consensus can be formed between the terminally ill patient, their loved ones, and their carers, that voluntary euthanasia is reasonable and desired.

Compassionate clinicians can experience enormous pressure to grant a dying person's wish for a hastened death. In these circumstances, I believe clinicians should have protection from prosecution for the most serious crime of murder.

Voluntary euthanasia is ethically distinct from murder, because of respect for autonomy and compassion (rather than sinister motives), yet parliamentarians have been reluctant to distinguish them in law.



Dr Philip Nitschke

In 1996, Philip Nitschke became the first physician in the world to administer a legal lethal voluntary injection to four terminally ill patients under the Northern Territory's *Rights of the Terminally Ill Act*.⁽¹⁵⁾ When the law was overturned nine months later, Philip founded Exit International; an international end of life choices group with a focus on practical strategies. Philip has written extensively on voluntary euthanasia and is the author of two books: *Killing Me Softly: Voluntary Euthanasia and the Road to the Peaceful Pill* (Penguin, 2005) and *The Peaceful Pill Handbook* (Exit International USA, 2013).



In the intervening 16 years since the Northern Territory *Rights of the Terminally Ill Act* came and went, the debate on voluntary euthanasia has been extended beyond those who are terminally ill, to include the well elderly for whom rational suicide is one of many end of life options.

This new cohort consider end of life planning in the form of rational suicide as an insurance policy should their health take a turn for the worse. As the baby boomer generation ages, the shift away from a medicalised approach to death and dying can be expected to accelerate, making way for a more democratic model of DIY (do it yourself) methods which are predicated upon widely-held notions of independence, control and self-sufficiency.

My focus in recent years has been the provision of information about forms of access to Nembutal – the best end of life drug – as well as the use of inert gases (such as nitrogen and helium). These technologies serve to de-couple end of life decision-making from a hitherto medicalised model of death and dying controlled by the medical profession.

On the legislative front, there remain two key unresolved issues. The first of these concerns section 122 of the Australian Constitution which allows the Government of Australia to make laws for its territories. This section constitutes a loophole by which the laws of the democratically elected government of the Northern Territory (and the Australian Capital Territory)

can be overturned. The preparedness of the Australian Parliament to exploit this Constitutional weakness remains a significant impediment to voluntary euthanasia law reform nationally.

The second area of legislative concern is the mismatch between the lawfulness of suicide and the illegality of assisted suicide. The legal nexus between suicide and assisted suicide needs examination. The fact that countries such as the UK have seen fit to publish guidelines on assisted suicide (without actually changing the law) suggests that Australia could, as a first tentative step, make similar considerations with a view to adopting similar guidelines.



Dr Helga Kuhse

was the Director of the Centre for Human Bioethics at Monash University where she is now an Honorary Adjunct Research Fellow.



Existing legal understandings that allow various medical end-of-life decisions, but prohibit “voluntary euthanasia” are unfair and unjust. They treat patients experiencing similar intolerable pain and suffering arbitrarily, in discriminatory ways.

A patient who needs life-support can lawfully refuse it, thereby bringing about her/his own death, with the assistance of a doctor. A patient not needing life support cannot lawfully draw on the assistance of doctors to end their lives.

Legislation to allow voluntary euthanasia would place all incurably and/or terminally ill patients on an equal footing; it will allow for openness and oversight and may well – as various overseas studies have shown – reduce (rather than increase) the incidence of non-voluntary and involuntary euthanasia in Australia.



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Hon Bob Brown

is a medical doctor, environmentalist, former Senator and former Parliamentary Leader of the Australian Greens.



Legislation is much more likely to succeed if it requires the patient, not the doctor, to self-administer the lethal drug.

The strongest opposition in the political arena comes from palliative care advocates who, wrongly, tell politicians that given enough funding, palliative care will be able to make every dying person content.

This opposition is most unreasonable when it comes from Catholic palliative care doctors, cardinals and ethicists.

Ideally, bills for voluntary euthanasia should be hosted by members from each of the political parties in that parliament and should involve a conscience vote.



Roundtable Participants

Mr Paul Barratt AO

Chair, Australia21

The Hon Emeritus

Professor Peter Baume AC

Former Health Minister
and University Chancellor

Mr Jack Boyd

Law/Commerce Student

Dr Bob Brown

Former Leader, Australian Greens

Professor Colleen Cartwright

Professor of Aged Care,
Southern Cross University

Dr Paul Collins

Historian, Writer and Broadcaster

Dr Richard Denniss

Director, The Australia Institute

Emeritus Professor Bob Douglas AO

Retired Epidemiologist (Chair)

Dr Charles Douglas

Surgeon and Ethicist

Mr Richard Eckersley

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Mr Neil Francis

Former Chair and CEO,
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Dr Roger Hunt

Palliative Care Physician

Dr Helga Kuhse

Ethicist, Monash University

Dr Yvonne Luxford

CEO, Palliative Care Australia

Emeritus Professor Ian Maddocks AM

Senior Australian of the Year,
Palliative Care Physician
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Dr Alex Markwell

President, AMA Queensland,
Emergency Physician

Mr Richard Mills

President, Dying with Dignity NSW

Dr Philip Nitschke

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Choice for Voluntary Euthanasia



Hon Professor Peter Baume AC

is a former Senator and Health Minister in the Fraser Coalition Government and former Chancellor of the ANU.



Voluntary euthanasia goes on every day – but without supervision, without advice from colleagues, and without rules.

Involuntary euthanasia occurs in intensive care units now.

Access to most goods is unequal in society and this is likely to be the case with voluntary euthanasia (and access to good quality palliative care).

The ethical principle of autonomy of the individual is not accepted by some people and some cultures positively reject the principle.

Religious belief does play a role here.

People who want voluntary euthanasia are worse off (in regard to voluntary euthanasia) in hospital (or in a nursing home) than they are at home.

It is legal now to kill oneself but the legal methods are all messy.



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The steering committee for this project included Mr Paul Barratt AO, Mr Richard Eckersley, Mr Marshall Perron, Professor Peter Baume AC, Dr Charles Douglas, Mr Richard Mills, Professor Lindy Willmott, Professor Ben White and Professor Bob Douglas AO.

We are also particularly grateful for use of facilities at QUT, to the Vice Chancellor, Professor Peter Coaldrake AO, who hosted a reception for participants, and to Ms Amy Henderson and her staff at QUT for logistic support.

Mr Marshall Perron

is a former Chief Minister of the Northern Territory. He was the architect and sponsor of the Northern Territory *Rights of the Terminally Ill Act 1995* which was overturned by Federal Parliament in 1997.



If there are terminally and incurably ill patients who wish to end their suffering by accelerating inevitable death and if there are sympathetic doctors who are willing to help them to die with dignity, then the law should not forbid it.

The law does forbid it and that is why I have been on a bit of a campaign to change that.

Currently the message that the Australian community is being given by its politicians is as follows:

“When you get really ill and near-death, go to the palliative care unit and they will do their best to help you but there is a chance they cannot.

If you don't want to go down that path then you can go and kill yourself and there is no law against suicide. We don't want you to but no one can stop you. You can go and hang yourself or shoot yourself. That is okay.

But if you want to have the family around for the hugs and tears and say goodbye, it is very hard to do that when you're going to hang yourself from the ceiling fan.”

Why can we not die in a peaceful tranquil way in the company of loved ones?



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